

**Identifying the Barriers for the  
Administration of Medication in Mainstream Primary Schools  
for Children with Chronic Illness**

**Submitted for the degree of  
MSc in Community Paediatrics  
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## INTRODUCTION

This dissertation describes a protocol, designed and “pretested” to identify the barriers that may exist for the administration of medication in mainstream primary schools in Southwark, for children with chronic illness. The protocol involves two hand delivered questionnaires; one to head teachers and the other to staff administering medication, in all primary schools in the area. The questionnaires are asking information regarding attitude, knowledge, and practice in order to identify the barriers that may exist for the administration of medication in schools by staff other than health. It looks specifically at medication administered for chronic illness as opposed to acute illness although some of the issues raised will be the same.

In this introduction I will begin by explaining why the research question is of interest and the diverse factors that are contributing to making administering of medication in schools an increasingly contentious issue. The complexity of issues lead to Bannon and Ross looking into who exactly is responsible for the administration of medication in schools <sup>5</sup>. Many children are required to take some form of medication during the school day, either short term or long term. The administration of medication in schools is an issue that affects every school, most teachers, many non teaching staff, children with special needs and their parents or carers. It is an area fraught with difficulties and varying advice. In many instances the need of the child may be in conflict with recommendations to school staff from the local education authority or their own trade unions. There are also legal, health and safety implications as well as practical issues such as the storage of medicines at school and record keeping.

I will then describe briefly, the procedures, guidelines and legislation currently in place to support pupils with medical needs in school, followed by Southwark’s own medication policy and its’ school health profiles and proposed core services for children with special educational needs in school.

After outlining the search methods used the introduction concludes with a statement of the aims of the protocol.

## **GOVERNMENT INITIATIVE**

Improving the achievements of children with special educational needs (SEN) is part of the crusade for higher standards launched with the present labour government's white paper "Excellence for all children meeting special educational needs"<sup>31</sup>. On the principal of inclusion it states that inclusion is a process not a fixed state. By inclusion it means not only that pupils with SEN should wherever possible receive their education in a mainstream school, but also that they should join fully with their peers in the curriculum and life of the school. On increasing inclusion it states that the ultimate purpose of SEN provision is to enable young people to flourish in adult life. Therefore there are strong educational, as well as social and moral grounds for educating children with SEN with their peers. Hence the government aims to increase the level and quality of inclusion within mainstream schools.

It endorses the UNESCO – Salamanca world statement on special needs education 1994 which states that "All children should be enrolled in regular schools unless there are compelling reasons for doing so otherwise.

Educators must aim to develop an education system in which specialist provision is seen as an integral part of overall provision. Mainstream schools will progressively expand their capacity to provide for children with a wide range of needs. Implementation must include collaboration with teachers, parents and students themselves.

The most recent step forward has been the SEN and Disabilities bill October 1998 which became an Act in May 2001. It relates to human rights legislation.

The government's green paper towards effective inclusion "Schools – Building on success"<sup>32</sup> is already in print, with key goals, equality of opportunity and every child reaching its full potential. Its inclusive strategy sees teachers as learners.

The Disability Rights Commission DRC has launched a four month major consultation on a new code of practice in July 2001<sup>33</sup>. A wide range of people including disabled pupils across Britain their parents and teachers are today being urged to give their views on the best way of enforcing educational rights which come into force next year in Sept 2002. The code will give practical guidance on how to avoid discrimination against disabled

pupils and students. The law can result in retrospective claims for damages. Until now disabled children and students have not had the legal right to education in mainstream schools, colleges and universities.

## **NEW TRENDS IN CHRONIC CHILDHOOD ILLNESS**

Asthma is the commonest chronic disease affecting children in the UK <sup>38,48</sup>. Estimates of prevalence includes both point prevalence and period prevalence. It is also important to note that currently there is no consensus on the definition of asthma in estimating prevalence. Four prevalence studies, which have been repeated over time with similar methods, have all reported that among British school children, the prevalence of asthma has increased in recent years <sup>17,18,55,82</sup> These serial prevalence studies have relied mainly on a single respiratory questionnaire which is completed by parents, though in one study <sup>18</sup> there was corroboration with an exercise test for bronchial hyperactivity. Anderson et al <sup>2</sup> screened all primary school children aged 7 ½ to 8 ½ years in the South London Borough of Croydon for a period of 13 yrs by a questionnaire completed by parents for symptoms of asthma followed by a detailed home interview which included a comprehensive assessment of the severity and impact of the disease A comparison of results found that there had been an increase from 11.1 % to 12.8 % (a 16% relative increase) in the prevalence of wheezing.

Not only is chronic illness common but inadequate treatment may impair a child's academic progress and general well-being <sup>20,77</sup>. Recent research suggests that for every thousand school children, as much as 128 may have symptoms suggestive of asthma <sup>2</sup>, 4 have a diagnosis of epilepsy established by the age of 12 years <sup>81</sup> and between 1 and 2 children have insulin dependent diabetes <sup>52</sup>.

A survey that looked at a random sample of 44 schools in the state of North Carolina distributed 399 questionnaires to a systemic sample of teachers in every school, identifying the nth roster name from a table of random numbers, identified asthma, diabetes and epilepsy as the most common illnesses in the classroom <sup>45</sup>. The survey assessed teacher needs in educating chronically ill children and gathered information from a broad sample of teachers. 86 % of 394 questionnaires distributed were completed and returned



The epidemiology of childhood illness too is changing. To date there is an increasing number of children presenting with “new disorders” which have implications for treatment protocols in schools. The most significant is peanut allergy. This presents as the most common cause of anaphylaxis with an incidence as high as one in two hundred <sup>79</sup>. Children with ADHD who require administration of methyl phenidate during school hours too face difficulties <sup>49</sup>. Other conditions to be considered include HIV <sup>58</sup>, haemoglobinopathies and sickle cell disease <sup>35</sup>.

Following the implementation of the 1981, 1993 and 1996 education acts an increasing number of children with substantial physical and medical disorders are receiving their education in main stream schools. <sup>36</sup>. Children with cystic fibrosis <sup>34</sup> malignant disease <sup>37</sup> surgical repair of congenital heart lesions, <sup>19</sup> tracheotomies <sup>21</sup> and gastrostomies are increasingly taught in mainstream schools.

When the new law on Special Educational Needs and Disability Act <sup>33</sup> comes into force in September 2002 it is likely that teachers in mainstream schools will encounter an even wider variety of childhood illnesses that may require treatment in school hours.

## **PARENTAL EXPECTATION**

Parents as defined in the Education Act 1944 – are a child’s main carers. They are responsible for making sure that their child is well enough to attend school. They should provide the head with sufficient information about their child’s medical condition, treatment and special care needs at school. They should, jointly with the head, reach agreement on the child’s medical needs. Parents have to administer medication to their children at home. Understandably they argue “Why can’t teachers do the same at school?”

The recent publication on patients and children’s charter <sup>53,54</sup> have encouraged many parents and children to insist that teachers should take responsibility for illness when children are at school. Increasing numbers of parental support groups such as Parents for Inclusion and Contact a Family <sup>28</sup> have made this lobby even more powerful. Parents argue that many devices and techniques enable non medical personnel to administer drugs effectively to children. These devices include asthma inhalers, rectal diazepam sachets,

and pre- loaded equipment such as the epi-pen which allows the administration of Adrenaline in the case of suspected anaphylaxis.

## **TEACHERS' CONCERNS**

Many school teachers are anxious about taking responsibility for medical rather than educational issues for which they have received insufficient or no teaching <sup>7</sup>. Storage of medicines in schools also raises concern <sup>64</sup>. A survey of school teachers' perception and knowledge of asthma in primary school children in 16 primary schools in Southampton (10 state schools selected at random from 75 and all 6 private schools) demonstrated that the responsibility for keeping and administering inhalers fell on the school secretary in 6 of the schools <sup>15</sup>.

Teachers have had little or no training in childhood illnesses that are common or chronic according to recent surveys carried out by health professionals on asthma <sup>10</sup> diabetes <sup>12</sup> and epilepsy <sup>6</sup>. Inadequate knowledge and training has been identified as the greatest teacher concern in the educational management of chronic illness. Other concerns identified were medical complications, impact on teacher time and legal liability <sup>45</sup>. Detailed recommendations which include all primary school teachers receiving teaching about asthma during their teacher training courses with regular in service training for those working in schools have been made. The recommendations state that medication for children (less than about 7 years) should be supervised by a responsible adult, preferably the class teacher <sup>10</sup>.

Another study in educating teachers in children's illnesses (asthma, epilepsy and diabetes) which used a self administered questionnaire determined that teachers had received some training in chronic illnesses during basic teacher training, though most felt their competency to cope with emergencies was limited <sup>57</sup>. They found updating sessions very beneficial. It was also encouraging that the majority of teachers requested more information. The study may not be generalisable as it was limited to 5 schools, even though it had a 83.3 % response rate.

However that many teachers were positive about the integration of children with chronic illness into mainstream education, was shown in a study, undertaken to look at how

school teachers perceived the school health service<sup>39</sup>. The study was compromised due to the poor response rate 26 out of 64 primary and post primary schools despite direct and personal communication.

A teacher's attitude plays a vital role in the management of chronic illnesses requiring medication in school. The attitude of school personnel may be the most single important factor for ensuring fair and proper treatment to children with potential life threatening food allergic reactions<sup>42</sup>. Researchers investigating the acceptability of behavioural and pharmacological investigations for children with attention deficit hyperactive disorder among primary and middle school teachers, recommended that before initiating a course of intervention, behavioural paediatricians might find it useful to contact teachers, to assess their perceptions regarding the acceptability of proposed strategies. They determined that teachers could be differentiated into several profile types with regard to their perception of treatment acceptability<sup>61</sup>.

A response to Bannon and Ross "administration of medicines in schools who is responsible"<sup>5</sup>, gave reasons as to why teachers reservations in administering medication to children is understandable<sup>51</sup>. To become a qualified teacher most teachers take the post graduate certificate of education after their first degree. The course which usually lasts for one academic year has varied educational and management orientated subjects that need to be mastered to become a teacher. This leaves little or no time to learn about childhood illnesses.

A number of teachers have approached their unions for advice on the question of administering medication to children with special needs. Some unions will fully support any members who do not wish to administer medication or those who feel that they are being unfairly pressurised to do so. (Appendix 1)

Some researchers have assessed the impact of asthma training programmes attended by school teachers. The results have been positive. In one study 50 primary school teachers who attended a one off seminar from each primary school resulted in a large increase in the preparation of schools with appropriate policies for the management of asthma in the school environment. The schools were randomly sampled and proportionally weighted to eliminate bias due to type of school and geographic location. 2 of the schools were lost to

follow up. There was significant difference ( $P < 0.0001$ ) in the contents of the asthma equipment in the school first aid kit before and after the seminar. Schools with a written asthma policy increased ( $P < 0.0001$ ) and requesting written instruction from parents about management of their child's asthma increased significantly ( $P < 0.0001$ ). The asthma educator conducted the survey by a 30 minute telephone survey. Researcher bias cannot be excluded <sup>43</sup>.

Another study implemented an asthma programme comprising of school asthma first aid kits , training work shops for school staff and individual crisis management plans for students with asthma. The programme was implemented in 1990 / 91 and evaluated in 1992. Teachers asthma knowledge and confidence with the management of acute asthma in school improved significantly ( $P < 0.001$ ). 96 % of teachers completed the knowledge questionnaire.<sup>72</sup>

Following a pilot study involving 2 primary school children with unstable epilepsy, whose treatment included rectal diazepam, all school nurses in Leicestershire had been trained in epilepsy awareness, setting up an administration programme for the safe administration of rectal diazepam, and the legal implications of volunteers administering medication in schools. The school nurses initiated the uninitiated. The study determined that it is possible to train staff in the mainstream education environment in the special health needs of children with unstable epilepsy <sup>47</sup>.

However training packages aimed at improving knowledge and good practice do not always achieve their desired objectives <sup>3</sup>. The aims of the project were to investigate teachers knowledge of asthma and to evaluate the effectiveness of an information session offered by an organisation charged with educating the community about asthma. There were no significant differences in knowledge of asthma between teachers who attended the seminar and those who did not. The attrition rate in the experimental group was 35% and 30% in the control group. The non responders were found to be no different to those who remained in the study.

Others have assessed teachers' knowledge about asthma and looked at correlates : associations with personal experience with an asthmatic child, involvement with health

education and being asthmatic themselves. These studies had unacceptable levels of non respondents (60% and 48.7 %) that were not followed up <sup>8,14</sup>.

A recent publication on anaphylaxis and epinephrine auto injection,” who will teach the teachers” challenged the current methods of educating professionals as well as patients <sup>41</sup>. These views were reiterated by other researchers who recommended improved patient and physician education to ensure proper use of this life saving medication <sup>74</sup>. Professionals clearly must have the skills and knowledge to be trainers.

## **SCHOOL HEALTH SERVICE**

Most parents have had some contact with the School Health Service (SHS) and are aware that each school has a named school nurse and school doctor. The school nurses who are state registered, often having specialist qualifications in nursing sick children seem ideally placed to administer medication in school. However the reality is that the school nurse cannot be available full time during school hours as the service has been reduced in most districts <sup>11</sup>. A school nurse and school doctor has to cover many schools.

Data collected using a self administered questionnaire, among school teachers of children aged 5-16 years who attended a diabetic clinic, aimed to assess teachers knowledge of insulin dependant diabetes mellitus <sup>40</sup>. The survey determined that most teachers do not have an adequate knowledge of diabetes and that parents were the most common source of information in primary schools. Very few schools indicated that school health professionals were used as a source. The study was compromised by its low response rate of 59.8 %. Non responders were not followed up.

Another study undertaken to identify children using inhalation treatment for asthma established that pressurised inhalers were being given to children who are too young to use them or whose inhalation techniques had not been adequately checked. Most children showed improvement in the technique after instruction but further checks would be necessary to maintain this. There is need for such work to be done in schools. A school nurse with particular interest would have been ideally placed to monitor children’s use of inhalers and give advice to parents and teachers <sup>76</sup>.

The School Health Service is also intended to be preventive rather than therapeutic <sup>83</sup> from its inception in 1908. Its activities are based on health promotion and disease prevention. The recommended core activities for school nurses incorporates a structured school entrant health interview with the parent, screening for height, weight, visual acuity and hearing. It also provides for a general health check at specified ages <sup>44</sup>. A key activity of the school nurse is compiling a health profile for each school that outlines the health needs of each pupil <sup>4</sup>. This should be updated regularly.

## **SUPPORTING PUPILS WITH MEDICAL NEEDS IN SCHOOL**

Several voluntary support organisations have already produced excellent information about common child hood illnesses for teachers. Comprehensive awareness and training packages are available on asthma <sup>66,68,78</sup> diabetes <sup>67</sup> and epilepsy <sup>1,62</sup>. Specific guidelines are also available for pharmacists to implement good practice in mainstream schools <sup>59,60,80</sup>.

The American Academy of Paediatrics committee on school health recommends that each school inco-operates or considers certain specified sections of its guidelines in their schools medication policy <sup>24,25</sup>.

In addition some inter professional groups in the UK have carefully considered the issue. The British Association for Community Child Health (BACCH) have made recommendations that they advise should be included in local policy <sup>13</sup>. The Community Health sub committee of the Committee for Public Health and Medicine draws attention to the issues involved and defines aims for joint guidelines lead by the departments of health and education to enable local authorities to develop protocols at local levels. <sup>27</sup>

However one of the recent developments has been, the publication of, “Supporting pupils with medical needs in schools”<sup>30</sup>. It is a most welcome example of interdepartmental collaboration between health and education. It has been written in response to the concerns which heads and teachers have expressed about their responsibilities as the number of pupils with medical needs in mainstream schools have risen. It aims to clarify the legal framework within which schools should operate in supporting such pupils and considers four main areas.

- **THE COMPLEX LEGAL FRAMEWORK:** Includes the Health and Safety at Work Act 1974, The Education Act 1993 and The Medicine Act 1968. The conclusion is that there is **no legal or contractual duty** on school staff to administer medicines or supervise a pupil taking it. This is a voluntary role. The term **locoparentis** is irrelevant. Support staff may have specific duties to provide medical assistance as part of the contract. Teachers and school staff in charge of pupils have a **common law duty** to act as any reasonably prudent parent would to make sure that pupils are healthy and safe in school premises. This might in exceptional circumstances extend to administering medications and / or taking action. The children act 1989 provides scope for teachers to do what is reasonable for the purpose of safeguarding or promoting children's welfare in emergency situations such as on a school trip.
- **SCHOOL POLICIES :** Drawn up in partnership with parents and staff should support pupils with medical needs.
- **INDIVIDUAL HEALTH CARE PLANS :** Should be drawn up in conjunction with the parent and where appropriate the child and the child's carers. It should set out in detail the measures needed to support a pupil in school including preparing for an emergency situation.
- **DEALING WITH MEDICINE SAFETY :** Must be considered at all times. This includes administration, storage, and disposal of medicines. Medicines must be readily available in an emergency and not be locked away. Relevant school staff and the pupil concerned should know where the medication is kept.

The DfEE document – Supporting Pupils with Medical Needs A Good Practice Guide <sup>29</sup> provides a pack of proformas which can be adapted for use by schools, when administering medication. It also provides some basic information about medical conditions in children which most commonly cause concerns in school. i.e.: Asthma, Epilepsy, Diabetes and Anaphylaxis.

Having individual care plans in place for the safe administration of medication in schools is never as crucial as in the management of status epilepticus, anaphylaxis and severe hypoglycaemia. A committee report from the Adverse Reactions to Food Committee of the American Academy of Allergy and Immunology in response to a severe case of fatal allergic reaction to food <sup>85</sup> raises important points regarding the treatment of individuals during allergic reaction to food. The report stressed the need for parents, school nurse and another designated responsible individual such as the child's teacher to be trained to recognise the symptoms of impending anaphylaxis and promptly institute the proper therapy. It recommended that aqueous epinephrine in a form that can be easily administered by injection (Epi pen) be available and that a responsible individual be designated to administer the injection in the event of an allergic reaction to food <sup>26</sup>.

A case series reported on 6 fatal and 7 near fatal anaphylaxis episodes to foods in children and adolescents. 4 of the 6 fatal reactions occurred at school and none of these children had epinephrine available at the time of their reactions <sup>66</sup>. Following this report, the American Academy of Paediatricians' ad hoc committee on anaphylaxis in schools, amongst other recommendations, stated that if a school does not have a full time nurse, other school personnel should be trained in the recognition of anaphylaxis and the administration of epinephrine in the event of an anaphylactic emergency. Cafeteria personnel and the classroom teacher of any student with a history of anaphylaxis should be trained to recognise the symptoms of anaphylaxis and in the administration of epinephrine <sup>84</sup>.

A team leader of a community paediatric nursing team has described a scheme she set up including an individual care plan to improve the quality of life for children with nut allergy by educating parents and teachers <sup>56</sup>.

Another study which assessed the effect of an epilepsy education initiative on the management of epilepsy in Southampton schools, recommended the implementation of an individual seizure protocol for children with epilepsy. The investigators reported a significant improvement in the management of the child following a seizure after the education session ( $P < 0.005$ ), stating that it is only with the implementation of individual seizure protocols, that epilepsy management in schools will be improved. Improvement was assessed only in terms of the population who stated that they were



prepared to manage the children with special needs in school. The validity of the results are compromised by selection bias. The non response rate too cannot be estimated <sup>23</sup>.

Severe hypoglycaemia, characterised by loss of consciousness and / or seizures occurs with an alarming frequency in school age children. Most of these hypoglycaemic episodes were reported to have occurred during daytime, and are related to inappropriate food intake or failure to adjust insulin or consume more food to compensate for exercise. Parents have to be encouraged to inform the school of their child's diabetes and assist them in learning to care for their children. School nurses are not always available. Therefore other members of the school staff need to be educated about diabetes and individual protocols for preventing and / or treating hypoglycaemia need to be established

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## **REVISED SPECIAL EDUCATIONAL NEEDS (SEN) CODE OF PRACTICE**

Consultation has taken place on a draft code of practice between July and October 2000. It is intended that the final version of the code will come into force for the school year 2001/2002.

The consultation has drawn a positive response from most respondents who largely support the thrust of the revised code. This includes emphasis on :

- Identifying children's special educational needs as early as possible and the extended application of the code in the early years
- The involvement of pupils
- Working with parents and carers as partners in their children's education
- The context in which learning takes place, providing effective school based provision to support children with SEN
- Progress as an indicator of need

The move towards progress as an indicator of need moves away from the deficit model whereby funding is attached to a statement following unsuccessful interventions.

## **SOUTHWARK SCHOOL MEDICATION POLICY**

In Southwark, the joint policy (Local Authority, Health Authority, Education and Community Health South London NHS Trust) on giving medication in schools is included in a document, School Health Matters <sup>46</sup> (APPENDIX 2).

Medication when needed during school hours is usually expected to be taken at midday. The policy states that pupils are normally expected to administer their medication themselves although they may require support from school staff. Anyone may legally administer medication provided the doctor's instructions are followed exactly. The procedures and guidelines are categorised under:-

- Head Teachers and Staff responsibility
- Parents or Carer's responsibility
- Storage of medicines in schools
- Administration of medicines
- Administration of non-prescription medicines
- Recording
- Disposal
- Medicines for pain relief
- Information

The Southwark medication policy aims to ensure the safe administration of medication in its schools. Some of its procedures and guidelines, listed below, have implications on the ongoing debate regarding administration of medication in schools.

The Head Teacher should be aware that **no member of staff can be required to administer medication** to pupils.

Any member of staff who is prepared to administer medicines should only do so **under the strictly controlled guidelines** of its medication policy.

A member of staff who does take responsibility for administering medication **takes on a legal duty of care** to discharge the responsibility appropriately whilst taking every reasonable precaution.

Staff nominated to administer medication to pupils **will be covered by the Council's normal insurance agreement**, as long as they have taken **all reasonable steps** to follow procedures in the guidelines.

Medicines when not in use should normally **be kept in a suitable locked cupboard**.

Medicines that need to be immediately available to the pupil e.g. asthma inhaler , epipen, should be discussed individually with parents / carer in order to **ensure immediate access to medicines when required**

Normally pupils will be expected to self administer any medication . However, if a parent / carer requests pupils be supervised, **a nominated person who has received appropriate training may undertake this**.

## **SOUTHWARK MAINSTREAM PRIMARY SCHOOL PROFILES**

Information regarding the special needs of children in mainstream primary schools are collated, analysed and presented in different ways depending on who gathers the information and what specific purpose it serves.

### **Source 1**

Southwark education has recently installed an Educational Management Systems (E.M.S) data base that has enabled the following information to be accessed (tables 1,2 and 3). The term special educational need is used to describe the requirements of pupils with difficulties in one or more of the following areas emotional, social and / or physical development, learning and behaviour. Hence it is not necessary that, children identified as having special educational need for learning difficulty, necessarily have a medical condition that may or may not require medication in school.

TABLE 1

**STATEMENT OF SPECIAL EDUCATIONAL NEEDS FOR PUPILS IN  
MAINSTREAM PRIMARY SCHOOL  
(AS AT JANUARY 2001)**

	<b>No. of students</b>	<b>% of Roll</b>
Roll ( All pupils)	24,068	100
SEN (with statements)	466	1.94
SEN (without statements) (code of practice stages 1-4)	5,240	21.8

There are five stages of SEN

Stage 1 – A class teacher identifies a pupil’s SEN.

Stage 2 The class teacher is supported by the school SEN Co-ordinator (SENCO).

Stage 3 The school is supported by specialists from outside the school.

Stage 5 The pupil is given a statement.

TABLE 2

**SPECIAL SCHOOLS IN SOUTHWARK (PRIMARY)  
(AS AT AUGUST 2001)**

<b>Name</b>	<b>Type</b>	<b>Roll</b>
BEORMUND	Emotional and behavioural difficulties	28
CHERRY GARDEN	Severe Learning Difficulties including Autism	46
HAYMERLE	Moderate Learning Difficulties	88
	Total	162

- All children have a statement of educational needs.

**TABLE 3**

**PUPILS WITH STATEMENTS ANALYSED BY AGE AND PRIMARY NEED  
(AS AT AUGUST 2001)**

PRIMARY NEED	Age of child in yrs									
	3	4	5	6	7	8	9	10	11	Total
Autism	3	7	10	9	7	3	2	2	3	46
Dyslexia / Specific Learning Difficulties	0	0	0	0	1	1	2	3	1	8
Emotional & Behavioural Difficulties	0	1	2	6	7	10	6	10	12	54
Hearing Impaired	0	1	1	3	2	1	3	6	6	23
Learning Difficulties	4	11	32	44	39	59	69	73	103	434
Medical	1	1	5	3	1	2	2	2	3	20
Multi-Sensory Impairment	1	0	1	0	0	0	1	0	1	4
Physical Disability	1	4	1	2	0	7	2	4	5	26
Severe Learning Difficulty	0	0	3	6	6	3	6	5	6	35
Speech and Language	1	11	6	14	8	13	12	16	9	95
Visually Impaired	1	1	1	0	1	4	4	4	2	18
<b>Total</b>	<b>12</b>	<b>37</b>	<b>62</b>	<b>87</b>	<b>72</b>	<b>103</b>	<b>109</b>	<b>125</b>	<b>151</b>	<b>758</b>

- A child having more than one need will be classified under his / her primary need.
- The table includes early years centres(Nurseries), special schools, and out of Borough (i.e. pupils who reside in Southwark but attend schools in other Boroughs)
- Medical includes epilepsy, asthma, diabetes, attention deficit hyperactive disorder, food allergy, cystic fibrosis etc.
- There are 25 children with statements of special educational needs in early years provision (Nursery and day care)
- Although the data base provides up to date information regarding the number of children with special educational needs, and the proportion of those with and without statements, it is not possible to determine the number of children with any known disease entity.
- There are no population figures available for all children with statements of need..

## Source 2

Information about children with special needs was obtained from Community Health South London (CHSL) NHS Trust accessing their Patient Information Management System (PIMS) data base. The children with special needs, who are placed on the special needs module are identified according to a classification in the internal special needs register maintained by the CHSL Trust. Currently it includes all children with statements of special educational needs.

TABLE 4

**SPECIAL NEEDS REGISTER CHSL NHS TRUST  
(AS AT AUGUST 2001)**

<b>No. of schools</b>	<b>Roll</b>	<b>SNR</b>	<b>%</b>
<b>70</b>	<b>24,068</b>	<b>658</b>	<b>2.73</b>

- A proxy figure of roll as at January 2001 has been used. There is no official intake of pupils to schools following the spring (January) admissions. The next academic year begins in September.

The conditions on the special needs register were originally coded according to ICD 9 classification. ICD 10 codes have been in use for the last 3 to 4 years.

Many factors contribute to the inaccuracies and incompleteness of the information entered into the database.

- Coding difficulties
  - (a) A few conditions are known under more than one name  
e.g. Mongolism, Down syndrome, Trisomy 21, chromosomal abnormalities.
  - (b) Some conditions remain classified with ICD 9 codes whilst others carry ICD 10 coding.
- Inadequate training in coding. Training programmes are not well attended due to shortages / frequent turnover of school nursing staff and heavy caseloads.
- Removal of existing and inclusion of new entries not always done as advocated.

- Poor communication between hospital based acute paediatricians, GP's and community based child health services.

The following information regarding the number of children with common chronic illness that may require medication in school is taken from the special needs register maintained by CHSL NHS Trust.

**TABLE 5**

**NUMBER OF CHILDREN ON THE CHSL SPECIAL NEEDS REGISTER  
ATTENDING PRIMARY MAINSTREAM SCHOOLS  
(Common chronic illness that may require medication at school)  
(AS AT AUGUST 2001)**

<b>Disease / Condition</b>	<b>No. of children</b>
Asthma	54
Epilepsy	43
Diabetes	10
Hyperkinetic Disorders	60
Food Allergies	03
Cystic Fibrosis	03
Sickle Cell Disease	68

- Population figures are not available.

**Source 3**

**SCHOOL HEALTH PROFILES**

The School Health Profiles compiled by the CHSL NHS Trust gives information about the number of children with special needs attending schools in Southwark. These figures are collected annually by the school health nurses in Southwark. As mentioned earlier in Source 2 children with special needs are placed on the register according to a classification laid down by the Trust. Being classified as having special needs , according

to the Trust's special needs register does not necessarily mean that the child has special educational needs as defined by the Education Authority.

Unfortunately for various reasons the school health profiles have not been published for the last few years i.e. 1999 / 2000 and 2000 / 2001. The profiles for 1998 / 1999 are not available. The guidelines for compilation of school health profiles classifies information under 5 categories. Its objective has been to provide a comprehensive picture of school nursing activity as well as identifying health needs. According to the new guidelines circulated for 2000 / 2001, information on diabetes, epilepsy, asthma, haemoglobinopathies and acute allergy are included in Section2, whilst information on behavioural disorders are included in Section 3.

**The school health profiles 1997/1998 gives the following information.**

**TABLE 6**

**SCHOOL HEALTH PROFILES 1997 / 1998**

<b>Condition</b>	<b>No. of Children</b>	<b>%</b>
Asthma	1489	6.96
Haemoglobinopathies	75	0.35
Enuresis	310	1.45
Encopresis	35	0.16
Special Needs Register	881	4.12
Roll	21363	100

- The shortage of school nurses in Southwark and the impact of the recent national meningitis immunisation campaign on school nursing time have all contributed to the paucity of accessible information.
- The prevalence of these conditions is very likely to be much higher than these estimates reflecting the need for accurate up to date information.
- Conditions such as epilepsy diabetes and food allergy are now being included in the school health profiles. Figures not published to date.



## **CORE SERVICES FOR CHILDREN WITH SEN IN SCHOOLS**

The school health steering group of CHSL NHS Trust has identified core services for children with SEN in school. These are stated in its recently published (September 2001) document, "Service to children in schools". They are as follows :

### *1. Legal Responsibilities under the 1996 Education Act*

- Informing parents and the appropriate LEA when forming the opinion that a child under 5 may have special educational needs, Section 176, Education Act
- Responding in a timely way to requests for information, to include the Annual Review and 14+ review
- Health assessments under the education Act 1996 by doctors, nurses and therapists

### *2. Management of children with special needs in school*

- Identification and assessment, treatment / management and monitoring in partnership with parents and the young person / child
- Facilitating the inclusion of children with medical problems through writing health care plans and developing systems of support with mainstream schools
- Liaison with Special Educational Needs Co-ordinator / teachers, other services and agencies
- Contribution to Individual Education Plans and Transitional Planning

### *3. Advice and Training*

- Advice and training on individual needs to skill and empower service delivery
- Health promotion and education

## **LITERATURE REVIEW, SEARCH METHODS**

- The following databases were searched for relevant studies: MEDLINE (1966-2001), EMBASE (1981-2001), CINAHL (1982 - 2001) and ERIC (1965-2001), supplemented on PubMed for currency.

The following search strategy was used, with slight variations to reflect the differences in the database structure and indexing:

Search strategy: (OVID notation):

1. exp School health services or teacher\$.ti.
2. exp \*chronic diseases
3. exp \*asthma
4. exp \*arthritis
5. exp \*epilepsy
6. exp \*hypersensitivity or allerg\$.ti.
7. exp \*anemia, sickle cell
8. exp \*attention deficit disorder with hyperactivity
9. exp \*HIV infections
10. 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9
11. 1 and 10

References in relevant studies were followed up and authors publishing on the subject under investigation were identified.

For ERIC: simplified search: TI=(teacher\* or school health) and KW=(asthma or arthrit\* or epilepsy or allerg\* or HIV or chronic disease\*) 68 refs.

- A previous search was made on databases Medline (1966-2000) and Embase (1988-2000) using search strategy winspirs 2.1 (Appendix 3,4)

- Articles were requested from the British Library document supply centre, West Yorkshire, UK.
- One of the co-editors of a national good practice guide for shared care services was asked whether she was aware of any published work on the chosen topic.
- In addition, a consultant community paediatrician, the head of school nursing and a head teacher of an inner-city authority that changed its policy from integration to inclusion in 1990 were approached to find out if they were aware of any papers on the subject.

## **AIMS OF THE STUDY**

### **Primary Aims**

- To determine the attitude, knowledge and practice of head teachers and staff administering medication in school towards the same.
- To identify two groups, those conducive to administering medication in school, and those who are not, and look for any associations.
- To determine if staff administering medication have had training in common chronic childhood diseases and other relevant topics.
- To identify teachers concerns regarding administration of medication in schools.
- To ascertain their interest to know more about these illnesses and other relevant topics.

### **Secondary Aims**

- To discuss the context in terms of national policy and local resources.
- To develop recommendations for a way forward.

If one is able to determine the barriers for the administration of medication in mainstream primary schools, then it enables educators, policy makers and the school health services to design intervention strategies to:

- promote or positively change attitudes towards medication in school
- provide training and improve knowledge and practice
- remove barriers to the services within education

## **METHODS**

### **Study design**

A cross sectional study using a structured self administered hand delivered questionnaire is being used, as it will be relatively easier to collect unambiguous information which can be quantified and analysed.

### **Selection of Study Sites and Sample**

Primary schools in Southwark were targeted for the study as opposed to secondary schools, as the younger children would require more supervision and assistance with medication.

As Southwark has only 70 mainstream primary schools, all primary schools in the area will be included in the study (Appendix 5). Most schools have 3 or more persons administering or supervising medication in school. The head teacher and all staff who administer or supervise medication in schools will be included in the study. This will minimise any sampling error.

### **Questionnaire Design**

Three self completion questionnaires will be used, as it is less costly than interviews, requiring less time, energy and administration.

Questionnaire 1 (Appendix 6) for head teachers reflects the policies of the governing board and the headteacher who is responsible for the medication policy.

Questionnaire 2 (Appendix 7) is for staff administering medication in school.

Questionnaire 3 (Appendix 7) requesting demographic and personal information will be included with questionnaire (1) and (2).

The others that have to be considered in this issue and who are at the core of the controversy are the parents of children requiring medication in school and the children themselves. Most parents prefer to educate their children in mainstream schools and would argue that if parents can learn to use these devices safely, why cannot the teachers

7,29

As for the children, in all this conflict and debate, one must remember that the paramount issue is that children with special needs have rights, not only to equality of access to services, but access to the services which are best suited to their needs (UN Convention on the Rights of the Child 1989)

Parents and children have not been targeted in this survey.

The literature search did not identify any existing questionnaires that specifically addressed the present research question. However, it identified a needs assessment instrument (questionnaire) developed and piloted by researchers who investigated schools in North Carolina in 1986, for determining the educational management of children with chronic illness<sup>45</sup>. The information collated provided a useful database for assessing need.

Questionnaire items were derived from a number of sources. Literature review, brainstorming sessions involving head teachers and those administering medication, community paediatricians, informal discussions with parents and personal experience. The questionnaire comprises of a series of statements determining the respondent's attitude, knowledge and practice towards administration of medication in school.

The initial draft version containing 25 statements each was circulated among 5 colleagues who are experts in this field and all of whom have completed the MSc in community paediatrics. They were requested to comment on the layout, design, the wording of questions and other issues from a respondent's perspective. They were also requested to

rate each statement according to the extent to which it was favourable, unfavourable or ambiguous.

The statements, which were rated as favourable or unfavourable to the referent, were used in the final pre-piloted questionnaires.

The statements were then reworded so that half the statements reflected a favourable attitude if the respondent agreed, and the other half of the statements reflected a favourable attitude if the respondent disagreed.

A total of 16 statements in questionnaire (1) to headteachers and 16 statements in questionnaire (2) for staff administering medication were selected for use.

The advice of a medical statistician was sought.

Half of the first 16 statements in questionnaire (1) reflect attitude and the other half reflect knowledge and practice.

A value for each response was assigned.

For those reflecting attitude:

Favourable = 2 points

Unfavourable = 0 points

Undecided = 1 point

For those reflecting knowledge and practice:

Favourable = 2 points

Unfavourable = 0 points

Undecided = 0 points

Hence a total score would be interpreted as:

> 16 points indicate favourable attitudes, knowledge and practice towards referent

≤ 16 points indicate unfavourable attitudes, knowledge and practice towards referent

Half of the first 16 statements of questionnaire (2), reflect attitude whilst the other half reflect knowledge and practice.

A value for each response was assigned.

For those reflecting attitude:

Favourable = 2 points

Unfavourable = 0 points

Undecided = 1 point

For those reflecting knowledge and practice:

Favourable = 2 points

Unfavourable = 0 points

Undecided = 0 points

Hence the total score would be interpreted as:

> 16 points indicate a favourable attitude, knowledge and practice toward referent.

≤ 16 points indicate unfavourable attitude, knowledge and practice toward referent.

A further two statements (17,18) in questionnaire (1) for head teachers and four statements (17,18,19,20) in questionnaire (2) for staff administering medication, were included to determine chronic illnesses that require medication in school, training needs issues of greatest concern for staff in giving medication and interagency working practices.

Some of the statements have a descriptive element. This 'soft' qualitative information will be summarised as appropriate and be indicative of reason underlying responses.



## **Ethical Approval**

The secretary of the Guy's Hospital Research Ethics Committee was contacted. As the research involves no other subjects except teachers or school assistants to complete a questionnaire on views of administering medication during school hours, the advice was that ethics committee approval was not required for the study. A copy of the protocol was nevertheless sent to them to hold on record (Appendix 9).

## **Education Authority Approval**

Firstly, the director of Southwark Education will be contacted in writing seeking permission for an approach to be made to the head teachers of the local primary schools in order to conduct a survey among the school staff (Appendix 10). A statement outlining the aims, design and methods of the research and its justification accompany this formal request.

## **Piloting**

The questionnaires will be piloted before undertaking the survey with a small sample of the target population. Pilot studies will iron out difficulties before the main study starts. It helps to indicate what should be asked of a larger sample and aids the construction of appropriate response categories.

The questionnaires will be modified and refined further in the light of responses and comments.

## **Administration**

The three questionnaires are attractive and user friendly.

Questionnaires (1) and (3) will be delivered to head teachers and Questionnaires (2) and (3) to staff administering medication.

Based on existing evidence about maximising response rates, the questionnaires were printed on bright coloured paper and will be hand delivered by the school nurses with a

covering letter in a white window envelope<sup>75</sup>. The questionnaires were numbered so as to be able to identify non-respondents.

Ideally it is intended that all questionnaires be hand delivered by the named school nurse at the time of the survey. Recent research has shown that hand delivered questionnaires have a response rate significantly higher than postal questionnaires<sup>16</sup>.

However, due to shortages of school nurses nationally and even more so locally, some schools unfortunately may not have a named school nurse at the time of the survey. School nursing posts are being advertised in Southwark and it is hoped that they will be filled before the survey is undertaken, enabling all questionnaires to be hand delivered. If this is not the case, it would be interesting to compare the response rates of the two groups, those delivered by hand and others by postal delivery.

If the number of schools with no named school nurse at the time of the survey are very few, making meaningful comparisons not possible, the nurses covering these school will be asked to hand deliver the questionnaires.

The covering letters will be signed by the investigator and a free-post return envelope addressed to Community Health South London NHS Trust will be included with each copy of the questionnaire. Initial reminders will be hand delivered after 2 weeks, enclosing the questionnaires, covering letter and self addressed free-post envelope. A third reminder will be hand delivered by the school nurse 5 weeks after the initial one, once again enclosing the questionnaire, covering letter and free-post self addressed envelope to minimise the proportion of non-responders.

## **ANALYSIS**

The scoring system will identify two groups, those conducive to administering medication in schools, and those who are not.

A frequency distribution of demographic and personal factors in the two groups will be compared. Any associations will be analysed by 2 x 2 cross tabulation. An appropriate statistical package e.g. Epi Info will be used for analysis.

## **RESULTS**

The results of interest will be the proportion of head teachers and school staff with favourable/unfavourable attitude, knowledge and practice toward medication in school: compared with regard to sex, age, ethnicity, designation, type of school and past exposure to children with chronic illness.

The results will address the research question, identifying the barriers for the administration of medication in mainstream primary schools in terms of attitude, knowledge, and practice. It will also determine issues of great concern to school staff in giving medication to school children with chronic illness.

The results should indicate the current levels of teacher training in the educational management of children with chronic illness, in addition to reflecting their need for more information.

The qualitative information when summarised appropriately will identify reasons underlying positive or negative attitude.

## **DISCUSSION**

### **Methodological considerations**

Cross sectional surveys are descriptive epidemiologic studies and due to limitations inherent in their design, are in general useful for raising the question of the presence of an association rather than testing a hypothesis.

As the research question related to what peoples attitude knowledge and practices were, towards administering medication in mainstream schools, a questionnaire was considered to be the most appropriate research tool, even though the information obtained is often referred to as 'soft data'. Questionnaires also have the advantage of

being quick and easy to administer, and when self completed, are less costly than interviews.

Its disadvantage, possible lower response rates leading to non response bias, will be minimised by hand delivery and two reminders delivered two weeks and five weeks after the initial questionnaire.

If the response rate is still unsatisfactory, a random sub-sample of non responders will be contacted and invited to complete the questionnaire by phone. Although there are clearly limitations to comparability of the data obtained by post and phone, this might allow some inferences to be made about non response bias. It is likely that responders will differ systematically from non responders.

The questionnaires were structured and much thought was given to the wording to collect unambiguous information which can be quantified and analysed, enabling conclusions to be drawn.

The tendency towards choosing the middle response and the problem of acquiescence was addressed. Social desirability response bias was minimised through avoiding judgemental statements, although complete participant anonymity cannot be established as the questionnaires will require numbering to enable identification of non responders. However, respondents will be assured that identifying information would be destroyed at the data processing stage.

Efforts have been made to reduce researcher bias, by using neutral instructions and study descriptions. However it will not be possible to avoid respondents identifying the investigator as having a particular interest in school health matters, as I am a community paediatrician based in Southwark. Any researcher bias is likely to be misclassified randomly, as some would respond with answers that they think are wanted, while others will express their disapproval of having to take on what maybe conceived as a health professional's responsibility.

The draft questionnaires have been 'tried out' by five experts in the field who were critics of layout, design and wording of statements, questions and other issues as seen from a respondent's perspective.

The questionnaires will be piloted before they are administered and ideally re-piloted once it has been refined further.

The individual items in the final draft have been selected to enhance reliability of the questionnaires. Piloting, revising, re-piloting and further refining will achieve validity and reliability.

## Identifying the barriers

One would hope that the results of the survey illustrates that the majority of head teachers, and staff will have positive attitudes, adequate knowledge and good practice towards administering medication in mainstream schools.

Whilst one would support positive attitudes, reasons for negative attitudes should be explored. Analysis of the results and summarised qualitative information will hopefully highlight some of the specific issues that require targeting. Information and awareness programs to improve attitude for the better should be considered. However it must be recognised that there will remain a nucleus of school staff who have hard core attitudes that are unlikely to change.

The survey may determine associations of demographic and personal data with having favourable or unfavourable responses towards medication in schools. Any associations need to be further investigated. Correlations have been looked at before<sup>8,14</sup> and reported in the published literature, although some of the studies have been compromised by considerable attrition that has not been followed up.

Teacher knowledge and preparation about health conditions has been identified as a concern in previous research<sup>45</sup>. Teacher knowledge and practice are closely related to training and preparation about childhood chronic illness<sup>43,47,72</sup>. Recent publications have challenged the current methods of educating professionals as well as patients<sup>41</sup>. Some investigators have recommended improved patient and physician education for more effective use of life saving medication<sup>74</sup>. Conversely research has shown that training programs do not necessarily achieve their desired objectives<sup>3</sup>. Again, one is aware that improved knowledge does not necessarily translate into appropriate behaviour.

Inclusion of planned education on chronic childhood illness in undergraduate and teacher training courses is varied<sup>15,57</sup>. Teachers are also known to gain knowledge during in-service training and from voluntary programmes.

Medication policies and individual care plans are recommended for the safe practice of administering medication in mainstream schools<sup>23,26,56</sup>. There are national<sup>29</sup> and local<sup>46</sup> guidelines in the UK for supporting pupils with medical needs in mainstream schools and to facilitate safe practice. An analysis of policies regulating medication in all Ohio public schools<sup>64</sup> identified that while schools in some districts needed formal policies, others had policies and guidelines that were not implemented. The Massachusetts experience<sup>73</sup> resulted not only in the development of a medication administration policy for all schools in the state but also implementing the regulations throughout the state.

Background information suggests that individual care plans may not be drawn up for every child in Southwark and when in place do not always provide the detailed measures needed for an emergency situation. The Community Health South London (CHSL) steering group on school health has recognised this need and referred to it in their new policy document ‘Service to Children in School’ as part of its management of children with special educational needs in school. The document recommends that borough based groups are established to determine priorities based on local agenda and issues.

Indemnity issues has been identified as a significant concern to teachers and staff who taught children with chronic health conditions<sup>45</sup> and is likely to be shown by the results. The Southwark medication policy states that staff nominated to administer medication to pupils will be covered by the council’s normal insurance arrangements as long as they have taken reasonable steps to follow the procedures contained in their guidelines. This needs further clarification. Does ‘medicines’ include invasive medical procedures? What is meant by ‘reasonable steps?’.

It has been the experience of Barnados, one of the leading voluntary organisations providing care services in the UK, that the local councils’ insurance officers advice has always been the same: Insurance will be granted if one acts reasonably and is seen to have taken reasonable steps. Barnados came up with a policy that was best explained by its circular nature incorporating legal liability, basic training, child health assessment, linking and matching, specific training, reviewing and monitoring leading to insurance<sup>50</sup>.

Implementation of this policy had required lobbying directed at both health and social services. The Royal College of Nursing (RCN) had been approached through their paediatric adviser, who was able to advise on permitted and prohibited tasks within the procedure (Appendix 13). The conditions are that the carer has received appropriate training specific to an individual child, and that the carer's ability is regularly assessed. The date that the assessment is due should be documented and the health professional responsible for carrying out the assessment clearly stated. Issues of interagency cooperation were looked at. The coming together of practice and lobbying enabled guidance to be produced in two publications<sup>63,71</sup>.

Teacher union support could provide a great boost to teachers faced with the task of administering medication in schools. However proclamations that unions will fully support any member who does not wish to administer medication and who feel that they are being unfairly pressurised to do so, presents a huge barrier to the service (Appendix 1)..

One of the most important results of the survey which will have a direct bearing on targeting resources, is the proportion of teaching staff administering medication compared to non-teaching staff.

Whatever the reason may be (which hopefully will be identified by the study) background information suggests that in most schools administering medication is mainly the responsibility of special support assistants and office staff, competent in first aid procedures.

Care of pupils with complex needs like tracheostomies and gastrostomies in special schools too, is often the responsibility of special support assistants.

This raises some issues. At present there are no prerequisite training or educational qualifications necessary to appoint special support assistants. Background information suggests that most schools do ask for GCSE passes in English and mathematics for those who support children in years 5 and 6. Some schools make those who do not have educational qualifications sit for an appropriate test in English and mathematics before offering employment.



Schools are becoming more aware of the reality of increased inclusion with the new special educational needs and disability act that will be enforced in September 2002. Some schools in Southwark are channelling resources to provide office staff and special support assistants who care for children with complex needs, training in first aid, organised by the Southwark local authority. Some are working towards the goal of having at least one competent first-aider on each site at all times.

The results of the survey may reflect that with the current scarcity of teachers, the impact on teacher time is a major concern in administering medication. Currently a schools academic success is assessed by SAT's (Standard Attainment Tasks) and Ofsted (Office for Standards in Education) inspections. While a few schools do dis-apply a few children with complex health needs from taking the SAT's, no recognition is given to children with special needs who reach their own individual targets.

It is unfortunate that school nurse shortages have not been resolved in Southwark despite recruitment efforts made by the Trust during the last 1-2 years. There are issues of retention too. One should not be complacent with the view that the local situation is a reflection of what is happening nationally. It has been recommended that school health services should be resourced according to need<sup>4</sup>.

It is indeed very concerning that the school health profiles compiled by the school nurses which identify health needs have not been published for the last 3 years in Southwark. This is despite the definition of a health profile for each school being identified as a key activity of school nursing<sup>4</sup>.

With the focus of school health being preventive rather than therapeutic and the recent impact of the National Meningitis Immunisation Campaign on school nurses time, how does one prioritise special needs?

It is encouraging that the Trust's school health steering group has recommended a co-ordinated multidisciplinary approach to the delivery of services to children in schools and

that they have prioritised the management of children with special needs in defining core services.

One must also consider other resources available to the school. Whilst some investigators identify parents as the most useful teacher resource<sup>45</sup> others have identified specialist nurses as being useful too<sup>40</sup>. In Southwark, background information suggests that paediatric home care nurses and diabetic liaison nurses are good training resources.

Some physicians concerned with the dilemma facing these children are reviewing their prescribing practices to avoid medication in schools. This should be encouraged. Various combinations of short and long acting insulin preparations are being prescribed pre-breakfast and pre-supper for children with insulin dependent diabetes mellitus IDDM, to avoid the pre-lunch injectable dose at school. Long acting methylphenidate (Ritalin) usually unavailable due to prohibitive cost has been prescribed when warranted. Children with unstable bladder problems too have been advised to take the afternoon dose of Oxybutenin as soon as they return home from school.

Studies assessing the effect of buccal midazolam for treatment of status epilepticus may lead to it becoming the preferred emergency treatment for its convenience of administration and social acceptability<sup>69,70</sup>.

Some of the barriers to the service that may be identified by the results of the survey have already been discussed. There are other key messages emerging for reinforcing standards of good practice in providing medication in schools. These are, a coordinated multi-agency working practice, policy development, practice and lobbying, legislation and appropriately targeted resources.

Currently the health authority and community trust retain the purchaser provider split. Southwark has Primary Care Groups which will evolve to Primary Care Trusts by April 2002. When the Primary Care Trusts take over, the purchaser provider split will no longer apply. However, performance management monitoring will be operated by the strategic health authority and the regional office. These changes may have implications on purchasing, allocation of resources and effective delivery of services.

It is evident that gaps in existing legislation and lack of clear guidance has created a situation in which there is little joint planning or co-ordination between the main agencies. There is a lack of clarity about whose responsibility it is to support these children resulting in confusion for the agencies, individuals who work in them, families and their children. There are wide variations in the level of support offered by schools, education authorities, health authorities and community trusts.

Some NHS trusts, which have already adopted an inclusive policy without incorporating multi-agency planning from the very onset, are facing difficulties in meeting service provisions of these children, as resource requirements of one agency or another have been overlooked.

The government has already provided the lead with the DfEE document 'supporting pupils with medical needs, a good practice guide'<sup>29</sup> and the revised SEN code of practice that comes into force in the school year 2001 / 2002. This is being followed by the new law on special educational needs and disability act, which will be enforced in September 2002. This places an obligation on schools to meet the health needs of children with special needs.

Currently schools in Southwark in conjunction with the education authority carry out an assessment of needs in order to determine what advice, assistance and support are needed. These joint health and education plans are drawn up in conjunction with health authorities in partnership with the child and parent.

Barriers to the administration of medication in schools in Southwark that are identified by the survey should be addressed.

Identifying and prioritising need and evidence based allocation of resources for the effective delivery of services will be the way forward.

This survey will be the first step in achieving this objective. It has been an expedition into unknown territory and hopefully will encourage further research.

## **THE WAY FORWARD**

There is a need for action at a number of levels; in individual schools and the local authority, between NHS professionals and teachers, and through strengthened national guidance.

- Simple educational programs, such as periodic rehearsal of emergency situations on simulated patients or the use of computer generated teaching programs for school staff will be of benefit.
- Detailed individual care plans and even named members of school staff for children with life threatening and complex health care needs will alleviate teacher concerns as well as ensure safe practice in schools.
- Staff identified for administering medication in schools should have basic educational requirements necessary for training and carrying out delegated tasks.
- There should be sufficient numbers of trained and competent staff available in school to enable safe medication at all times as the designated person maybe unavailable at any one time. Effort should be made to enable children with SEN access school trips and extracurricular activities.
- Further research is necessary
  - to explore the most effective methods of teaching the teachers specific types of information relevant to the educational management of children with chronic illness.
  - to identify the deficiencies in teacher training of chronic illness to enable appropriate recommendations to be made to education authorities.
  - to identify which resources teachers view as most helpful to support children with SEN thereby enhancing evidence based targeting of resources.

- An audit is recommended to assess whether schools in Southwark have medication policies which conform to national/local guidelines and whether they are being implemented effectively
- It is good practice for schools too, to maintain up to date health profiles of their own, although this is likely to provide an under estimate of health needs due to issues of confidentiality.
- Schools will have to make decisions as to whether they channel resources for training their teaching staff or employ and train suitable special support assistants who in the near future, may well have to care for children with life threatening and complex medical needs in mainstream schools.
- Although there are many avenues for accessing information regarding children with special needs, the difficulties experienced in collating relevant information highlights the need for effective and comprehensive information systems. It is also necessary for the different information systems to be correlated for effective and meaningful data analysis.
- There should be no delay in implementing the Trust's new policy document 'Service to Children in School' effectively.
- It is necessary to investigate the difficulties experienced by the Trust in the recruitment and retention of school nurses in Southwark. It would also be useful to look at neighbouring inner-city boroughs to see how they are managing the school nursing crisis and possibly learn from their experience.
- More research is required for the use of buccal midazolam in the normal community setting which would help confirm the most effective initial treatment with least toxicity by the most appropriate route for prolonged seizures.
- It is recommended that, section 5 of a pupils statement of special educational needs should continue to be properly recorded by the education authority and

reviewed annually by a relevant multi-agency panel. It should also be fully enforceable by the special educational needs tribunal to ensure that these health needs are met.

- It should be made a legal requirement for health authorities to provide comprehensive training for school staff on administering medication. Funds should be allocated to allow health authorities to discharge this responsibility. Specific training should not only be provided but take place within negotiated time periods of a schools initial request.
- It is recommended that the education authority and DfEE design an assessment tool for measuring a schools' progress in children with special needs achieving their individual education targets. . This would provide an incentive for schools to take on children with complex needs.
- It is suggested that the department of health set a national standard for school nursing services with increased levels of service where needed, so that children with SEN in mainstream schools can be supported.
- Professional bodies, local councils, health and education authorities need to be approached and lobbied. Co-ordinated multi-agency policies that identify financial responsibility should be developed. Full indemnity not only for school staff administering medication but also for health professionals who train others to carry out medical procedures should be provided. Guidance should be sought from the shared care net work and their experience with the carer model.
- It is suggested that the DfEE and the Department of Health should negotiate with teachers' unions to promote new guidance to their members by providing reassurance on indemnity and other related issues.

The 1999 Health Act which came into force in April 2000 maybe a way forward. It gives an opportunity to look at pooled budgets, joint commissioning and provision of services. An opportunity to be seized.

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# Health & Safety Representatives' Training

## MEDICINES IN SCHOOLS

### Session Briefing

**This briefing sets out the legal position of teachers with regard to administration of medicines to pupils and NUT policy guidance on this area, which is designed to protect the rights of individual teachers whilst ensuring that the health and safety of pupils is safeguarded.**

#### ***Summary of NUT Advice***

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- < There is no legal or contractual duty on school staff to administer medicine or to supervise a pupil taking it. This is a purely voluntary role and is recognised as such by the DfEE. While teachers have a general legal duty of care to their pupils, this does not extend to a requirement to routinely administer medicines.
- < Teachers should be particularly wary about agreeing to administer medicines to pupils where:
  - the timing of its administration is crucial to the health of the child; or
  - some technical or medical knowledge is required; or
  - intimate contact with the pupil is necessary (this would include administration of rectal valium, assistance with catheters or use of equipment for children with tracheotomies).
- < Teachers who do volunteer to administer medicines should not agree to do so without first receiving appropriate information and training.
- < The **NUT** will fully support any members who do not wish to administer medicines or who feel that they are being unfairly pressurised to do so.

#### ***Children with Long Term Health Problems***

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The NUT recognises that it is desirable for children with long term recurring health problems, such as asthma, epilepsy and diabetes, to be accommodated within school in order that they can continue their education.

For this to be done, however, proper and clearly understood arrangements for administration of medicines must be made. Parents should be encouraged to provide maximum support and assistance in helping the school accommodate the pupil. This would include measures such as self-administration (where necessary and only after approval from a GP) or parental supervision as outlined below.

Where this is not feasible, the following procedure is recommended:

- (a) The smallest possible dose should be brought to the school, preferably by the parent, with clear written instructions for administration, giving the name of the pupil. Glass containers are unsuitable to be carried by pupils. (Note: It is not practicable to bring one measured dose of a liquid medicine: adhesion of the liquid to the container results in the dose being less than sufficient).
- (b) The medicine should not be kept by the pupil but in a locked cupboard out of reach of pupils. Certain medicines, however, such as inhalers, used by asthmatic children, must be made readily accessible at all times of the school day. The means by which this is done would remain a matter for headteachers= professional judgement or LEA guidelines.
- (c) The medicine should be self-administered if possible, under the supervision of an adult. This may be the headteacher or someone acting with the headteachers= authority. It would be advisable to keep a written record of the date and time of the administration.

Further guidance on these and other matters is given in the NUT=s leaflets on medicines in schools and in the DfEE=s good practice guidance.

## ***Sources of Guidance***

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### ***< DfEE/DoH Good Practice Guide***

The DfEE and Department of Health have produced detailed A good practice= guidance entitled >Supporting Pupils with Medical Needs=. This guide, which was drawn up in consultation with teacher organisations, LEAs and health authorities, confirms the voluntary nature of teachers= involvement. It advocates school-based policies and procedures for supporting pupils with medical needs and includes detailed advice on a range of the most common conditions - asthma, epilepsy, diabetes and anaphylaxis - and detailed guidance on safe storage of medicines and on routine and emergency procedures for medical matters.

DfEE/DoH Circular 14/96: >Supporting Pupils with Medical Needs in School= and >Supporting Pupils with Medical Needs : A Good Practice Guide= are available free of charge from DfEE Publications Centre, PO Box 5050, Sudbury, Suffolk CO10 6ZQ (tel: 0845 6022260/fax: 0845 6033360).

### ***< Local Authority Guidelines***

The LEA has principal responsibility for the safety and welfare of pupils. It is essential, therefore, that LEAs issue detailed policy guidelines to all schools, clarifying the areas of responsibility for medicines, together with the procedure to operate should there be a need for medication to be administered in school. Where an LEA has issued guidelines which accord with the principles set out in this briefing, members should follow them carefully. If no such guidelines have been issued or they do not meet criteria set out in this briefing, members are advised to contact their NUT Division/Regional Office to seek clarification of their own position and to seek to ensure that proper guidelines are issued to schools as a matter of urgency.

## ***Action Points for Safety Reps***

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Make sure that:

- < your school has a copy of the DfEE Good Practice Guide;
- < your colleagues are aware of their responsibilities and rights; and
- < an agreed and satisfactory plan of medical care exists for each pupil with special medical needs in the school.

## ***Teachers= Obligations***

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Teachers= conditions of service do not include any legal or contractual obligation to administer medicine or to supervise a pupil taking medicine. While teachers have a professional duty to safeguard the health and safety of pupils and a general legal duty of care towards pupils both when they are authorised to be on the school premises and when they are engaged in authorised school activities elsewhere, this does not imply a duty upon teachers personally to undertake the administration of medicines.

The NUT advises that teachers who do volunteer to administer medicines should not agree to do so without first receiving appropriate information and training. The local NHS Trust or Health Authority is in a position to advise schools on the source of the support required. In many areas this support will be provided through the School Health Service.

As noted earlier, the NUT advises that teachers should be particularly wary about agreeing to administer medicines to pupils where the timing of its administration is crucial to the health of the child; or where some technical or medical knowledge is required; or where intimate contact with the pupil is necessary (this would include administration of rectal valium, assistance with catheters or use of equipment for children with tracheostomies).

The NUT also advises that any teacher who is prepared to administer medicines should only do so under strictly controlled guidelines, fully confident that the administration will be safe. It is wise to limit this willingness to emergency situations only. Every reasonable precaution must be taken. Clear instructions about medicines requiring regular administration must be obtained and strictly followed.

Any decision to agree to administer medicines has to be a matter of individual choice and judgement. Apart from the obvious distress to a teacher who makes an error, all teachers who agree to administer medicines take on a legal responsibility to do so correctly. There is consequently always the risk that the teacher might be named in a legal claim for negligence. Generally, however, any teacher acting in accordance with agreed procedures would be regarded as acting in the interests of the employer and, since the employer would also be the subject of the action, the teacher would therefore be effectively indemnified against personal liability by the rules of >vicarious liability=.

In cases of accident and emergency, teachers must, of course, always be prepared to help as they and other school staff in charge of pupils have their general legal duty of care to act as any reasonably prudent parent would. In such emergencies, however, teachers should do no more than is obviously necessary and appropriate to relieve extreme distress or prevent further and otherwise irreparable harm. Qualified medical treatment should be secured in emergencies at the earliest opportunity.

The NUT will fully support any members who do not wish to administer medicines or who feel that they are being unfairly pressured to do so. In such cases, support and assistance should be sought from the NUT regional/Wales Office immediately. Advice is always available on aspects of NUT guidance or on particular cases as well.

## ***School Policies and Individual Pupils= Medical Care Plans***

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A clear policy on supporting individual pupils with medical needs should be established within schools and understood by staff, parents and pupils. In addition, a medical care plan should be drawn up and agreed for every pupil who may need medical care during the school day.

Parents are responsible for their child=s medication and children who are genuinely unwell should not attend school. Headteachers are, however, responsible for deciding whether the school can assist a pupil who needs medication during the school day.

Many pupils with long-term medical conditions will not require medication during school hours. Those that do may be able to administer it themselves. If this is not the case then the Union advises that, wherever possible, parents should be asked to make arrangements to come into school or for pupils to return home at lunchtime for medication.

## SCHOOL HEALTH MATTERS

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### GIVING MEDICINE IN SCHOOLS

Policy Example:

#### Introduction

A few pupils, while fit to attend school, may need to take medicines in school hours (usually at midday.) Although pupils will normally administer their medicines themselves, they may require support from school staff. Anyone may legally administer medication provided that the doctor's instructions are followed exactly.

For the most part this guidance refers to prescribed medicines. However, the same issues also apply to non prescribed medicines and this aspect is specifically covered in para. 5 below.

#### 1. **Headteacher and staff's responsibility**

The Head shall ensure that a named person is responsible for medicines in each school, together with a nominated deputy. The day-to-day process of giving medicine may be delegated to competent, trained colleagues. The Headteacher should be aware that no member of staff can be required to administer medicines to a pupil.

It should be noted that, unless prior arrangements have been agreed with the school health authorities, Headteachers should not accept responsibility for the administration of medication to pupils where:

- a) the precise timing of its administration is crucial to the health of the pupil
- b) some technical or medical knowledge and/or specialist training is required
- c) intimate contact with the pupil is necessary. This would include administration of rectal diazepam, assistance with catheters, or use of equipment for pupils with tracheostomies

Any member of staff who is prepared to administer medicines should only do so under the strictly controlled guidelines as described in this document, fully confident that the administration will be safe. A member of staff who does take responsibility for administering medicines takes on a legal duty of care to discharge the responsibility appropriately. Every reasonable precaution must be taken.

Staff nominated to administer medicines to pupils will be covered by the Council's normal insurance arrangements as long as they have taken all reasonable steps to follow the procedures contained in these guidelines.



## **2. Parent's or Carer's Responsibility**

a clear written statement of parental responsibilities should be given to all parents/carers, preferably on admission, detailing:

- how to make a request to the Headteacher or Deputy for medicines to be given at school by completion of the attached for 'Request for Storage and Administration of Medicines in School' (example form enclosed.)
- how medicines should be provided to the school. Medicines must be provided in original dispensed container fully labelled with the following information:

Pupil's name, name of medicine, full directions for use and date of dispensing. Parents/carers may need to consult their GP or pharmacist in order to clarify this or obtain an additional labelled container for use in school.
- the need for the parent/carer to notify the school in writing of any changes in medicines or doses to be given
- the need for the parent/carer, in person, to replenish the supply of medicines if necessary
- a requirement that the parent/carer advises the school nurse of any significant medical condition or allergy their child may have, subject to confidentiality. The Headteacher should be informed by the parent/carer if their child is having medical treatment.
- confirmation that if the doctor has said a medicine should be taken once or twice a day it should normally be given at home rather than at school (i.e. wherever possible the need to give medicines at school should be avoided.)

## **3. Storage of medicines in Schools**

Medicines, when not in use, should normally be kept in a suitable locked cupboard. Medicines requiring refrigeration may be kept in a closed container within a domestic refrigerator, which must not be accessible to pupils.

It is recommended that certain medicines need to be immediately available to the pupil, e.g. asthma inhalers. It is recommended that this is discussed individually with parents/carers in order to ensure immediate access to medicines if required. The practice of pupils holding their own inhalers should be encouraged. (This is applicable to both Primary and Secondary school.) Although inhalers are open to misuse in the wrong hands, the risks of pupils not having immediate access to their inhalers are much greater than the risk of misuse by other pupils.

## **4. Administration of medicines**

Normally pupils will be expected to self administer any medication. However, if the parent/carer has requested that the pupil be supervised, then a nominated person who has received appropriate training may undertake this. The school should be informed of all medicines held by a pupil.

## **5. Administration of non-prescription (over the counter) medication**

- a) The same general procedures should be followed as with prescription medication
- b) all medication should be brought in to school in the original container bearing the manufacturer's instruction/guidelines
- c) parents should complete the form 'Request for storage and Administration of Medicines in School.' (Example enclosed.)

Dosage must not exceed the manufacturer's instructions.

- d) school staff have the right to refuse to administration of any medication if: -
  - i) it does not carry the manufacturer's instruction/guidelines
  - ii) the nature of the medication is unclear/unfamiliar.

## **6. Recording**

The administration of all medicines in school and those stored centrally must be recorded in the school medicine record sheet (example enclosed.) For any pupil requiring more than one medicine to be administered a separate school medicine record sheet should be completed for each medicine.

The label on the medicine container should be checked against the details on the 'Request for Storage and Administration of Medicines in School' form (completed by the parent/carer) and the school medicine record sheet. Any discrepancy should be queried with the parent/carer before administering the medicine. A parent/carer should confirm their intentions in writing if their instructions differ from those in the medicine container.

## **7. Disposal**

Medicines no longer required should be returned to the parent/carer for disposal at the earliest opportunity, and this should be recorded on the school medicine record. If this is not possible, they should be returned to a community pharmacy for destruction.

## **8. Medicine for pain relief**

Paracetamol is the only non prescribed pain relieving drug, which may be given to pupils. Parents should be informed of the school's policy in relation to the administration of paracetamol on admission, and parents/carers should inform the school if they wish their child to receive paracetamol under these circumstances.

Paracetamol may be given in either liquid or tablet form in a dose appropriate for the pupil's age according to the instructions in the container. This dose may be given **ONCE ONLY** during the school day. If a second request is made by the pupil, the Headteacher should consider whether the pupil is well enough to remain in school.

The administration of paracetamol should be recorded in a book identified for this purpose and kept with the container on paracetamol. It is advisable that parents/carers should be informed when paracetamol is given to their child.

Paracetamol may be dangerous if an overdose is taken. The keeping of paracetamol (or any other) tablets in first aid boxes or in any place accessible to pupils is expressly forbidden.

## **9. Information**

Additional information about individual medicines and their correct use may be obtained through the school health services (i.e. school nurse.)

# SCHOOL HEALTH MATTERS

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## REQUEST FOR STORAGE AND ADMINISTRATION OF MEDICINE IN SCHOOL

In order for your child to be supervised during the administration of any medicines at school, the following information is required to be completed by the parent/carer and sent to the Headteacher or deputy. If there are any subsequent changes in medicines or doses to be given, then these must be notified immediately to the school. All doses given during school hours, whether by pupil or staff, will be recorded on the school medicine record sheet.

Name of pupil: .....

Class: .....

Name of medicine (to include full details as given on the containers label issued by the pharmacist.)

Dose and when to be taken.

Any additional information (about medicine.)

Contact telephone number.

Any prescribed medicine must be supplied to the school in a container clearly labelled (by the pharmacist) with the name of the medicine, full instructions for use, and name of the pupil. Any non-prescribed medicine should be in the original container bearing the manufacturer's instructions/guidelines. The school staff may refuse to administer any medicines supplied in inappropriate containers.

This form should be renewed by the parent /carer at the beginning of each term for pupils on long-term medication.

School:	<b>SCHOOL MEDICINE RECORD</b>
Name:	Please refer to container label for appropriate instruction. Please initial clearly against the time when dose is given.
Address:	

<b>DETAILS OF MEDICINE, DOSE AND WHEN TO BE ENTERED HERE</b>	<b>Day</b>	<b>Mon</b>	<b>Tue</b>	<b>Wed</b>	<b>Thur</b>	<b>Fri</b>	<b>Day</b>	<b>Mon</b>	<b>Tue</b>	<b>Wed</b>	<b>Thur</b>	<b>Fri</b>	<b>Day</b>	<b>Mon</b>	<b>Tue</b>	<b>Wed</b>	<b>Thur</b>	<b>Fri</b>
	Date						Date						Date					
	Time						Time						Time					
	Initial						Initial						Initial					
	Time						Time						Time					
	Initial						Initial						Initial					
	Time						Time						Time					
	Initial						Initial						Initial					
	Day	Mon	Tue	Wed	Thur	Fri	Day	Mon	Tue	Wed	Thur	Fri	Day	Mon	Tue	Wed	Thur	Fri
	Date						Date						Date					
	Time						Time						Time					
	Initial						Initial						Initial					
	Time						Time						Time					
	Initial						Initial						Initial					
Time						Time						Time						
Initial						Initial						Initial						

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**SCHOOL HEALTH MATTERS**

## APPENDIX 3

WinSPIRS 2.1

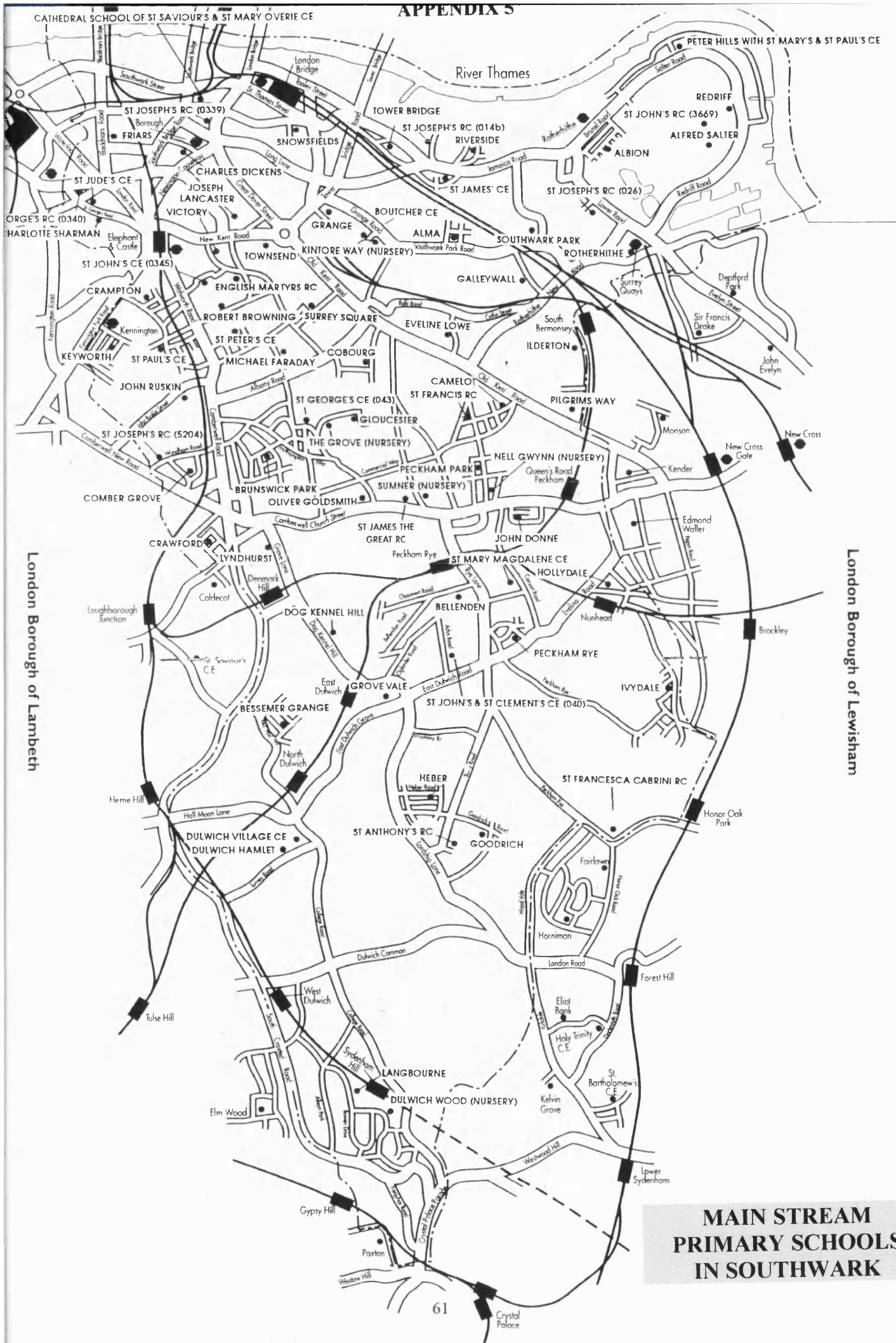
No.	Request
1	medicat*
2	MEDICATION in TI,AB,DE
3	explode "drug-therapy"/ all subheadings
4	school
5	school in de
6	"primary-school"/ all subheadings
7	"school"/ all subheadings
8	"high -school"/all subheadings
9	#4 r #5 or #6 or #7 or #8
10	#9 and #2
11	#2 or #3
12	#9 and #11
13	special
14	need*
15	special need*
16	#15 and #12
17	LA = "ENGLISH"
18	#10 and (LA = ENGLISH")
19	child*
20	infant*
21	#19 or #20
22	#18 and #21
23	randomi*
24	#23 and #22
25	rectal
26	diazepam
27	rectal diazepam
28	"diazepam"/ drug-administration
29	EPILEPSY in TI,AB,DE
30	explode "epilepsy"/ all subheadings
31	#28 and #30
32	#31 and #21
33	#32 and #9
	searches and records above from: Selected Database
34	"Administration, - Rectal"
35	DIAZEPAM in TI,AB,MESH
36	explode "Diazepam"/ administration-and-dosage
37	school*
38	school* in ti,ab
39	#34 or #35
40	#39 or #36
41	#37 or #38
42	#41 and #40
43	child*
44	infant*
45	child* or infant*
46	#45 and #42
47	randomi*
48	#47 and #46
49	peanut
50	allergy
51	peanut allergy
52"	Peanuts"/ adverse-effects
53	#52 or #51
54	epipen
55	EPIPEN in TI,AB,MESH
56	explode "Epinephrine"/ all subheadings
*57	#56 and #53

## APPENDIX 4

### WinSPIRS 2.1

No.	Request
1	bannon
2	ross
3	bannon and ross
4	School-Health-Services*
5	drug
6	therapy
7	social
8	responsibility
9	teaching
10	school-Health-Services* and drug therapy and (social responsibility or teaching)
11	health
12	education
13	patient
14	compliance
15	health education or patient compliance
16	social
17	responsibility
18	teaching
19	social responsibility or teaching
20	#15 or #19
21	school
22	health
23	chool health
24	#20 and #23
25	drug
26	therapy
27	medication
28	medicine*
29	drug therapy or mediation or medicine*
30	drug
31	therapy
32	medication
33	medicines
34	drug therapy or medication or medicine
35	#34and #24
36	PATIENTS COMPLIANCE in TI,AB,MESH
37	"Patient-Compliance"/all subheadings
38	cot
39	death
40	cot death
41	COT DEATH in TI,AB,MESH
42	"Sudden-Infant-Death"/ all subheadings
43	SCHOOL HEALTH in TI,AB,MESH
44	explode "school-health-Services"/ all subheadings
45	#44 and #37
46	#45 not #35
47	explode "Chronic -Disease" / all subheadings
48	#47 and #44
49	#48 not #35 not #46
50	asthma*
51	hyperactiv*
52	epipep*
53	adhd
54	diabet*
55	tacheost*
56	hickman*
57	cystic
58	(asthama* in ti) or (hyperactive* in ti) or (epilep* in ti) or adhd or (diabet* in ti) or 62 (tacheost* in ti) or (hickman* in ti) or (cystic in ti)
59	peanut
60	#58 or (peanut in ti)
61	(#60 and 44) not #48 not #46 not #35

APPENDIX 5



MAIN STREAM  
PRIMARY SCHOOLS  
IN SOUTHWARK



**APPENDIX 6**

**SURVEY ON THE ADMINISTRATION OF MEDICATION IN SCHOOLS**  
**Questionnaire 1 - Head Teachers**

The contents of this form are confidential.

Please tick the box which reflects your view best.

1. Children with chronic illness requiring medication in school should be able to receive their medication in school.

- AGREE                       DISAGREE                       UNDECIDED

Any comments ?.....

2. School staff do not have enough time to administer medication in schools.

- AGREE                       DISAGREE                       UNDECIDED

Any comments ?.....

3. It is not necessary for every pupil receiving medication in school to have a detailed individual care plan drawn up by an appropriate health professional and agreed to by parent/ carer.

- AGREE                       DISAGREE                       UNDECIDED

Any comments ?.....

4. The DfEE good practice guidelines for supporting pupils with medical needs is helpful in ensuring safe practice in administering medication in schools.

- AGREE                       DISAGREE                       UNDECIDED

Any comments ?.....

5. There are too many children with special needs that require medication attending this school.

- AGREE                       DISAGREE                       UNDECIDED

Any comments ?.....

6. All children with asthma attending primary school who are prescribed inhalers should be responsible for their own inhalers.

- AGREE                       DISAGREE                       UNDECIDED

Any comments ?.....

7. It is sufficient to have one member of staff designated to administer medication in school.

- AGREE                       DISAGREE                       UNDECIDED

8. Opportunities for attending refresher courses relevant to the administration of medication in school must be made available to staff giving medicine.

AGREE                       DISAGREE                       UNDECIDED

Any comments ? .....

9. Appropriate arrangements should be made to enable pupils with medical needs to participate in school trips wherever safety permits.

AGREE                       DISAGREE                       UNDECIDED

Any comments .....

10. It is not necessary for staff administering medication in schools to have full indemnity.

AGREE                       DISAGREE                       UNDECIDED

Any comments ? .....

11. All staff administering medication must be trained and competent in carrying out the necessary treatment.

AGREE                       DISAGREE                       UNDECIDED

12. Every school should have a clear medication policy understood by staff, parents and pupils.

AGREE                       DISAGREE                       UNDECIDED

13. Training of staff should include guidance in safety measures for storage, handling and disposal.

AGREE                       DISAGREE                       UNDECIDED

14. It is not the head teacher's responsibility for making sure that medicines are stored safely.

AGREE                       DISAGREE                       UNDECIDED

15. Individual care plans should include guidelines on relevant emergency procedures.

AGREE                       DISAGREE                       UNDECIDED

16. It is acceptable to administer medication that has been re-packed by parents in a container other than their original dispensed container.

AGREE                       DISAGREE                       UNDECIDED

Please tick all that apply in the following questions.

17 Staff administering medication have received training in the following

- a. Common chronic childhood illnesses that may require medication in school (e.g. Asthma, Epilepsy, food allergy etc)
- b. Administering medication
- c. Side effects of medication
- d. Emergency procedures
- e. Record keeping
- f. Refresher courses
- g. Other (please specify).....

18 The school policy for supporting pupils with medical needs includes working with the following

- The child
- Parents / carers
- School Health Service
- Community Paediatric home care team
- Specialist liaison nurse eg. diabetes
- Community Paediatrician
- Community therapists e.g. Occupational, speech
- GPs
- Health professionals based in hospital
- Social services
- Voluntary organisations
- Other (please specify).....

---

If you would like to make any comments about this questionnaire please write them here.

*Please turn over for a few questions about you.*

**SURVEY ON THE ADMINISTRATION OF MEDICATION IN SCHOOLS**

**Questionnaire 2 - Staff administering medication**

The contents of this form are confidential.

Please tick the box which reflects your view best.

1. Children with special needs should be included in mainstream schools wherever possible.

AGREE                       DISAGREE                       UNDECIDED

Any comments ?.....

2. Children with chronic illness requiring medication in school should be able to receive their medication in school.

AGREE                       DISAGREE                       UNDECIDED

Any comments ?.....

3. Administering medication in schools should be carried out only by health professionals.

AGREE                       DISAGREE                       UNDECIDED

Any comments ?.....

4. Each pupil receiving medication in school should have a detailed individual care plan drawn up by an appropriate health professional, agreed to by parents including handling emergency situations.

AGREE                       DISAGREE                       UNDECIDED

Any comments ?.....

5. I do not like administering medication by mouth to children with chronic illness or supervise inhaler use in children with asthma

AGREE                       DISAGREE                       UNDECIDED

Any comments.....

6. If I were to work in another school I would not administer medication to pupils.

AGREE                       DISAGREE                       UNDECIDED

Any comments ?.....

7. Although I give medication in school I do not feel competent to do so.

AGREE                       DISAGREE                       UNDECIDED

Any comments ?.....

8. If I was trained and certified as competent I would administer rectal diazepam(insert an anal suppository ) for children with diagnosed epilepsy who have a seizure lasting more than 5 minutes as advocated in their individual care plan.

AGREE                       DISAGREE                       UNDECIDED

Any comments ?.....

9. All children with Asthma attending primary school who are prescribed inhalers should be responsible for their own inhalers

AGREE                       DISAGREE                       UNDECIDED

Any comments ?.....

10. I have access to the school health service if I need specific information

AGREE                       DISAGREE                       UNDECIDED

Any comments ?.....

11. It is acceptable to administer medication that has been re-packed by parents in a container other than their original dispensed container.

AGREE                       DISAGREE                       UNDECIDED

12. Any unused or out of date medication must be disposed of in the waste bin.

AGREE                       DISAGREE                       UNDECIDED

13. It is necessary to record details of medication given to pupils.

AGREE                       DISAGREE                       UNDECIDED

14. There are voluntary organisations that produce excellent information on chronic childhood illnesses for teachers and non teaching staff

AGREE                       DISAGREE                       UNDECIDED

15. It is not always necessary to abide by the guidelines and procedures of the medication policy.

AGREE                       DISAGREE                       UNDECIDED

16. I think this survey is relevant to mainstream education.

AGREE                       DISAGREE                       UNDECIDED

Please tick all that apply in the following questions.

17. I have to supervise or give medication to children with the following conditions:-

- a Asthma
- b Epilepsy
- c Attention deficit hyperactivity disorder
- d Food allergy
- e Diabetes
- f Cystic Fibrosis
- g Sickle Cell Disease
- h Other(please specify).....

18. I have had training in the following illnesses:-

- a Asthma
- b Epilepsy
- c Attention deficit hyperactivity disorder
- d Food allergy
- e Diabetes
- f Cystic fibrosis
- g Sickle cell disease
- h Other(please specify).....

19. I need training in :-

- a. Childhood chronic illnesses
- b. Administering medication in schools
- c. Side effects of medications that I am expected to give
- d. Emergency procedures
- e. Record keeping
- f. Guidance in safety procedures
- g. Other (please specify).....

20. The issues of greatest concern to me in administering medication to children with chronic illnesses are –

- a. Knowledge / Training
- b. Complications of medication
- c. Emergency procedures
- d. Legal liability
- e. Impact on teacher time
- f. Other (please specify).....

---

If you would like to make any comments about this questionnaire please write them here.

*Please turn over for a few questions about you.*

## APPENDIX 8

### Questionnaire 3

Please complete this section about yourself, by placing a tick in the correct box.

Your name is not required. The contents of this form are confidential as before.

1. Are you  Male  Female

2. What is your age ?

- Under 25
- 25-34
- 35-44
- 45-54
- 55 and over

3. Are you

- |                                      |  |  |
|--------------------------------------|--|--|
| <input type="checkbox"/> White UK    | <input type="checkbox"/> White Irish   | <input type="checkbox"/> White other     |
| <input type="checkbox"/> Black UK    | <input type="checkbox"/> Black African | <input type="checkbox"/> Black Caribbean |
| <input type="checkbox"/> Black Other | <input type="checkbox"/> Chinese       | <input type="checkbox"/> Indian          |
| <input type="checkbox"/> Pakistani   | <input type="checkbox"/> Bangladeshi   | <input type="checkbox"/> Other           |

4. What is your designation ?

- Head Teacher
- Teacher
- Learning Support Assistant
- First Aider
- Other

5. Have you attended a first aid course in the last 12 months ?

- Yes  No  Don't know

If yes 1) Please give the name of the course.....

2) Is the training currently valid ?

- Yes  No  Don't know

6. How would you categorise the school you work in ?

- County school maintained by Southwark Education
- Church of England
- Roman Catholic
- Grant maintained
- Other.....

7. Do you belong to a union (e.g. National Teachers Union, National Association of Head Teachers etc) ?

- Yes  No  Don't know

If yes, 1) Please give the name of your union.....

2) Does your union support giving medication in school ?

- Yes  No  Don't know

8. Have you had exposure to children with chronic illnesses prior to your present appointment ?

- Yes  No  Don't know

1) If yes, in what capacity ? eg:- teacher, support assistant, parent etc. ....

- 2) For how many years ?
- < 10 yr.
  - 10 – 20 yrs
  - > 20 yr

68  
*Thank you very much for your help with this survey. Please return it in the free post envelope.*

11 July 2001  
2001/08

Dr Dil Abeyakoon  
Community Paediatrician  
St Giles' Hospital  
St Giles' Road  
London SE5 7RN

Dear Dr Abeyakoon

**Re: Identifying the barriers for the administration of medication in mainstream primary schools in Southwark, for children with chronic illness**

Thank you for your email dated 5 July 2001 regarding the above protocol which you plan to submit as part of your MSc in Community Paediatrics. My understanding is that it is the intention to ask teachers or school assistants to complete a questionnaire about views on administering medication during school hours.

On this understanding and presuming that no other subjects are involved, I do not think this requires an application to the Research Ethics Committee.

It is also my understanding that the study at present is theoretical only.

Yours sincerely



Steven H Sacks  
Chairman of the Guy's Hospital Research Ethics Committee



Community Health South London   
NHS Trust

St Giles Hospital  
St. Giles Road  
London SE5 7RN

Tel: 020 7771 3344/3341  
Fax: 020 7771 3349

1 September 2001.

Mr. (Initials) (Surname)  
Director Southwark Education  
John Smith House  
144 – 152 Walworth Road  
London SE19 1JL

Dear Mr. (Surname),

**SURVEY ON ADMINISTRATION OF MEDICATION TO CHILDREN WITH  
CHRONIC ILLNESS IN MAINSTREAM SCHOOLS.**

I am a community paediatrician employed by with Community Health South London NHS Trust in Southwark.

I am writing to obtain permission to contact Head Teachers and school staff administering medication, to children with chronic illnesses, in Southwark Primary Schools, to conduct this survey.

The aim of the survey is to identify the barriers that may exist in administering medication in primary schools in Southwark. Copies of the questionnaires are attached for your perusal.

The results of the survey will enable the School Health Service to provide ongoing support for head teachers and school staff administering medication so that children with chronic illnesses will have access to an education best suited to their needs. It will also enable Southwark to move forward in achieving the objective of inclusion.

If you have any queries regarding the survey or the questionnaires please do not hesitate to contact me on 0207 017 0010

Yours sincerely

Dil Abeyakoon  
Community Paediatrician.

1 September 2001.

Mr. / Mrs. (Initials) (Surname)  
Head Teacher  
Name of School  
Address.

**St Giles Hospital**

St. Giles Road  
London SE5 7RN

Tel: 020 7771 3344/3341

Fax: 020 7771 3349

Dear Mr. / Mrs. (Surname),

**SURVEY ON ADMINISTRATION OF MEDICATION TO CHILDREN WITH CHRONIC ILLNESS.**

I am a Community Paediatrician employed by Community Health South London NHS Trust.

I am writing to ask for your help regarding a survey on administration of medication to school children. Permission to conduct this survey has already been obtained from the Director of Education in Southwark.

I am conducting a survey on the views of head teachers and school staff administering medication to children with chronic illnesses. I shall be grateful if you would spare the time to complete the attached questionnaire. I also seek your support to give the questionnaire to members of your staff administering medication to children in school.

The survey aims to determine the barriers that may exist for the administration of medication to children with chronic illnesses. As you are aware Southwark is working towards an inclusive policy and the survey is being conducted in all its' primary mainstream schools.

Your responses will be completely confidential. No individual will be identifiable from the survey results. The number on the questionnaire is only for me to follow up on those who may not have responded and will be destroyed at the data processing stage. I have enclosed a freepost envelope for reply. If I have not heard from you in two weeks a reminder will be hand delivered.

The results of this survey will enable the school health service to provide better support to head teachers and school staff who administer medication, .

If you have any queries about the questionnaire or the survey please do not hesitate to contact me on 0207 017 0010.

Thank you for your help with this survey.

Yours sincerely

Dil Abeyakoon  
Community Paediatrician

1 September 2001.

Mr. / Mrs. (Initials) (Surname)  
Head Teacher  
Name of School  
Address.

**St Giles Hospital**

St. Giles Road  
London SE5 7RN

Tel: 020 7771 3344/3341

Fax: 020 7771 3349

Dear Mr. / Mrs. (Surname),

**SURVEY ON ADMINISTRATION OF MEDICATION TO CHILDREN WITH CHRONIC ILLNESS.**

I am a Community Paediatrician employed by Community Health South London NHS Trust.

I am writing to ask for your help regarding a survey on administration of medication to school children. Permission to conduct this survey has already been obtained from the Director of Education in Southwark.

I am conducting a survey on the views of head teachers and school staff administering medication to children with chronic illnesses. I shall be grateful if you would spare the time to complete the attached questionnaire. I also seek your support to give the questionnaire to members of your staff administering medication to children in school.

The survey aims to determine the barriers that may exist for the administration of medication to children with chronic illnesses. As you are aware Southwark is working towards an inclusive policy and the survey is being conducted in all its' primary mainstream schools..

Your responses will be completely confidential. No individual will be identifiable from the survey results. The number on the questionnaire is only for me to follow up on those who may not have responded and will be destroyed at the data processing stage. I have enclosed a freepost envelope for reply. If I have not heard from you in two weeks a reminder will be hand delivered.

The results of this survey will enable the school health service to provide better support to head teachers and school staff who administer medication.

If you have any queries about the questionnaire or the survey please do not hesitate to contact me on 0207 017 0010.

Thank you for your help with this survey.

Yours sincerely

Dil Abeyakoon  
Community Paediatrician

**Community Health South London** 

NHS Trust

**St Giles Hospital**St. Giles Road  
London SE5 7RN

1 September 2001.

Mr. / Mrs. (Initials) (Surname)

Designation

Name of School

Address.

Tel: 020 7771 3344/3341

Fax: 020 7771 3349

Dear Mr. / Mrs. (Surname),

**SURVEY ON ADMINISTRATION OF MEDICATION TO CHILDREN WITH CHRONIC ILLNESS.**

I am a Community Paediatrician employed by Community Health South London NHS Trust.

I am writing to ask for your help regarding a survey on administration of medication to school children. Permission to conduct this survey has already been obtained from the Director of Education in Southwark and your head teacher has been informed.

I am conducting a survey on the views of head teachers and school staff administering medication to children with chronic illnesses. As you are aware Southwark is working towards an inclusive policy and the survey is being conducted in all its primary mainstream schools.

The survey aims to determine the barriers that may exist for the administration of medication to children with chronic illnesses.

Your responses will be completely confidential. No individual will be identifiable from the survey results. The number on the questionnaire is only for me to follow up on those who may not have responded and will be destroyed at the data processing stage. I have enclosed a freepost envelope for reply. If I have not heard from you in two weeks a reminder will be hand delivered.

The results of this survey will enable the school health service to provide better support to school staff who administer medication,

If you have any queries about the questionnaire or the survey please do not hesitate to contact me on 0207 017 0010.

Thank you for your help with this survey.

Yours sincerely

Dil Abeyakoon  
Community Paediatrician

## APPENDIX 13

The Royal College of Nursing (RCN) has deemed these tasks **appropriate** under certain conditions.

They are :-

- Administration of prescribed medicine via a naso-gastric tube;
- Feeding through a nasogastric or gastrostomy tube;
- Tracheostomy suction and emergency change of tracheostomy tube;
- Injections (intramuscular or subcutaneous) with a pre assembled pre-dose loaded syringe;
- Intermittent catheterisation and catheter care;
- Rectal medication;
- Emergency treatments;
- Assistance with inhalers, insufflation cartridges and nebulisers;
- Assistance with oxygen administration;

The RCN also suggest that the following should be **prohibited** :-

- Administering non-prescribed medicine (staff or carers may not know whether medication may react with other medication taken);
- Giving injections involving assembling syringes, administering intravenously, or controlled drug;
- Programming of syringe drivers;
- Filling of oxygen cylinders ( This is prohibited under section 9 and 10 of the Medicines Act which states that “this can only be carried out by operators holding a manufacturers’ license”).
- Where non-prescribed medicines are needed (such as Calpol or cough mixture) they can be prescribed by the child’s doctor. This would help ensure safe administration by carers and avoid potentially harmful side-effects which might occur.